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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Jul/09/2012
IRO CASE #:
DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
MRI of the Lumbar Spine without contrast

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
Family Medicine

REVIEW OUTCOME:
Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:
[X] Upheld (Agree)
[ ] Overturned (Disagree)
[ ] Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether medical necessity exists for <u>each</u> health care service in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:
ODG - Official Disability Guidelines & Treatment Guidelines
Request for IRO 06/26/12
Utilization review determination 04/20/12
Utilization review determination 05/04/12
Clinical records Dr. 04/13/12-06/26/12
MRI lumbar spine 07/19/11

PATIENT CLINICAL HISTORY [SUMMARY]:
The claimant is a male who has a date of injury of xx/xx/xx. On this date he is reported to have injured his low back as a result of lifting. Records indicate that the claimant was referred for MRI of the lumbar spine on xx/xx/xx. This study notes bilateral spondylolysis with a grade 1 spondylolisthesis at L5-S1. There is decreased signal in the L4-5 and L5-S1 lumbar discs compatible with desiccation at L4-5 and L5/S1. There is a mild posterior bulging seen without a focal protrusion or annular tear. There was no spinal or neural foraminal stenosis with similar findings at L5-S1.

On 04/12/12 the claimant is reported to have developed low back pain when he jumped down a small step. He subsequently sought care from Dr. on 04/13/12. On physical examination he is noted to have lumbar spasm and negative straight leg raise. He is able to heel toe walk without difficulty. He was diagnosed with lumbar disc disease and muscle sprain. He was provided a prescription for Dexamethasone and Flexeril 10 mg.

Records indicate that the claimant was seen in follow-up on 04/17/12. At this time per the pain diagram he has focal low back pain with radiation to the posterior thighs. He was subsequently recommended to undergo MRI of the lumbar spine.

This request was reviewed on 04/20/12. The reviewer non-certified the request. He notes that there is no documentation of focal neurologic deficit on physical examination. He notes the previous lumbar MRI and that the claimant's physical examination does not show any new changes.

The claimant was subsequently seen in follow-up on 04/27/12. At this time, he is reported to have low back pain with radiation into the left lower extremity. A second request was placed for MRI of the lumbar spine. This appeal request was reviewed on 05/04/12. The reviewer notes that MRI from 07/19/11 documents bulges at L4-5 and L5-S1 with no canal or foraminal stenosis. The claimant has complaints of constant back pain and intermittent leg pain. The reviewer notes that there is no documentation of neurologic deficits and opines that the criteria per Official Disability Guidelines were not met.

The claimant was seen in follow-up on 05/18/12. He is noted to be able to heel toe walk without difficulty. SLR is reported to be positive. The claimant's pain diagram notes focal low back pain with radiation into the bilateral lower extremities. Records indicate that the claimant was referred for physical therapy. He was subsequently seen in follow-up on 06/01/12. At this time it is reported that his straight leg raise is negative. He was recommended to undergo physical therapy.

On 06/15/12 the claimant was again seen in follow-up. He is noted to have focal pain in the lumbosacral junction. The claimant is now reported to have positive straight leg raise. He is again recommended to undergo MRI of the lumbar spine.

The most recent clinic note is dated 06/26/12. The claimant is noted to have focal low back pain and straight leg raise is negative.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:

The request for MRI of the lumbar spine is not supported as medically necessary and the prior utilization review determinations are upheld. The submitted clinical records report a history of back pain associated with a lifting injury occurring on 07/13/11. This apparently appears to have remitted and he subsequently developed recurrent low back pain on 04/12/12. The claimant has previously undergone MRI of the lumbar spine which showed no evidence of neurocompressive pathology but did show early disc degeneration and evidence of a congenital defect with a spondylolisthesis at the L5-S1 level. The submitted clinical records do not establish that the claimant has any focal neurologic deficits. On physical examination the claimant's subjective reports vary from visit to visit with reports of low back pain with radiation into the bilateral lower extremities and low back pain radiating into the left lower extremity. Given these inconsistencies there is no clear indication for the performance of an MRI of the lumbar spine. It would further be noted that the first step in assessing the claimant's recurrent back pain would be the performance of plain lumbar radiographs. Given the inconsistencies in the claimant's clinical presentation and noting the lack of less sophisticated imaging, the request for MRI would not have been supported as medically necessary under the Official Disability Guidelines.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

[ ] ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE
[ ] AHCPR-AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES
[ ] DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
[ ] EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
[ ] INTERQUAL CRITERIA
[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
[ ] MILLIMAN CARE GUIDELINES
[X] ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
[ ] PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR
[ ] TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS
[ ] TEXAS TACADA GUIDELINES
[ ] TMF SCREENING CRITERIA MANUAL
[ ] PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
[ ] OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)